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CDC Promotes Public Health Approach To Address Depression among Older Adults

Did you know...

- ✓ 20 percent of adults age 55 and older have a mental health disorder (such as anxiety, cognitive impairment, or mood disorder) that is not part of normal aging (American Association for Geriatric Psychiatry, 2008).
- ✓ 15–20 percent of adults older than age 65 in the United States have experienced depression (Geriatric Mental Health Foundation, 2008).
- ✓ 7 million adults aged 65 years and older are affected by depression (Steinman, 2007).
- ✓ Chronically ill Medicare beneficiaries with accompanying depression have significantly higher health care costs than those with chronic diseases alone (Unützer, 2009).
- ✓ People with serious mental illness are more likely to die on average at age 51 from complications of unhealthy risk factors (such as smoking or obesity), compared with age 76 for all Americans (Parks, 2006).
- ✓ People aged 65 years and older accounted for 16 percent of suicide deaths in 2004 (Centers for Disease Control and Prevention, 2007).

"I didn't know anything about depression, so I didn't know I was depressed. ... The questionnaire was essential to getting me in for treatment. It was sent to me three times before I sent it back. I took medication and went to a class that helped me learn skills to work on the depression. ... I now have two friends getting treatment for depression since I told them about my situation."

– Participant in a depression care management program (CDC, 2009a)

An estimated 7 million of the nation's 39 million adults aged 65 years and older are affected by depression, which is a persistent sad, anxious, or empty feeling, or a feeling of hopelessness and pessimism. Depression in older adults is often not recognized or treated. Yet, it is fairly easy to detect, highly treatable, and a candidate for prevention efforts – making it an excellent focus for public health activities.

Depression is not a normal part of aging. While older adults may face widowhood, loss of function, or loss of independence, persistent bereavement or serious depression is not "normal" and should be treated (U.S. Surgeon General, 1999). Living with untreated depression presents a serious public health problem. Depression complicates chronic conditions such as heart disease, diabetes, and stroke; increases health care costs; and often accompanies functional

impairment and disability (Frederick, 2007; Katon, 2003; Snowden, 2008; Unützer, 1997).

Depression is also linked to higher health care costs (Unützer, 1997) and tied to higher mortality from suicide and cardiac disease (Frederick, 2007; Snowden, 2009).

Effective treatment reduces depressive symptoms and secondary symptoms such as pain, and improves functioning and quality of life (Frederick, 2007; Snowden, 2008). That means depression among older adults can be addressed through better community-based approaches to identifying and treating depression and through more public awareness.

This issue brief will examine community-based approaches to depression and the role of public health and the aging services network.

PUBLIC HEALTH ROLE

“The nation is now poised to take the next step toward realizing the vision of integrating mental health and public health described a decade ago in the Surgeon General’s report. Spiraling health care costs and the rising number of uninsured Americans have built momentum for health care reform, and it is clear that a population-based, public health approach – one that encompasses mental health – will be needed as a foundation for that reform.”

– David Satcher, M.D., Ph.D., Morehouse School of Medicine and former U.S. surgeon general

As the lead government agency for the nation’s public health, the Centers for Disease Control and Prevention (CDC) plays a central role in the efforts to integrate mental health and public health (Satcher, 2010). CDC’s Healthy Aging Program also has been working to link public health departments with the aging services network on mental health issues. CDC’s role in mental health of the aging includes collecting data to monitor the effect of depression on older adults, helping states assess their state and local data, gathering evidence for effective community-based programs, and promoting evidence-based interventions that can help adults maintain a healthy outlook.

The public health community can monitor depression in the population; develop, test, and start programs that address depression in older adults; and incorporate mental health promotion into chronic disease prevention efforts. In addition, the public health community can work with aging services and mental health providers to more readily reach older adults who may be depressed. “Routine, systematic screening can successfully identify adults who are depressed and direct them to appropriate treatment,” CDC concludes in its report *Promoting Preventive Services for Adults 50–64: Community and Clinical Partnerships* (CDC, 2009c).

CDC collects data on depression, anxiety, psychological distress, and mental illness stigma through supplemental mental illness symptom modules to the state Behavioral Risk Factor Surveillance System (BRFSS) questionnaire. The BRFSS is the world's largest, ongoing telephone health survey system, tracking health conditions and risk behaviors in the United States annually. In 2006, 38 states and three territories used a depression and anxiety module, according to CDC. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has funded the following number of states to add either the mental illness and stigma module or the depression and anxiety module to their BRFSS: 36 states in 2006; 35 states in 2007; 19 states in 2008; and 19 states in 2009 (Freeman, 2010).

In addition, since 1993 the BRFSS has included a question about number of mentally unhealthy days experienced. Mentally unhealthy days are those "when mental health was not good because of stress, depression, or emotional problems." Interestingly, a trend toward more mentally unhealthy days has been occurring for people in the 55–64 age group. This preretirement age group reported 2.7 mentally unhealthy days a month in 2000, rising to 3.4 days in 2008, the last year for which data is available (CDC, 2009b; Zack, 2004). "That is a significant trend," said Rosemarie Kobau, M.P.H., public health advisor in the Arthritis, Epilepsy, and Quality of Life Branch. Comparable numbers for ages 64–74 and 75+ were around 2.0 mentally unhealthy days a month in those same years.

CDC also collects information through the National Health Interview Survey, National Health and Nutrition Examination Surveys, and Medicare Health Outcomes Survey.

In addition to CDC, the U.S. Surgeon General, the Task Force on Community Preventive Services, *Healthy People 2010*, the White House Conference on Aging, and other experts have recognized depression as a significant public health problem among older adults.

- The U.S. Surgeon General identified older adults as a priority concern in its first report on mental health (U.S. Surgeon General, 1999). It concluded there are effective interventions for most mental disorders, such as depression and anxiety, experienced by older persons and for many mental health problems, such as bereavement.
- The Task Force on Community Preventive Services reviewed depression treatments and recognized several broad categories as appropriate for adults aged 60 years and older (TFCPS, 2007). It strongly recommended home-based depression care management and clinic-based depression care management. (See "Treating Depression" below).
- *Healthy People 2010*, the nation's health promotion and disease prevention initiative, aims to reduce the proportion of adults with disabilities who report feelings such as sadness, unhappiness, or depression that prevent them from being active (HHS, 2000).

- The 2005 White House Conference on Aging adopted a resolution to improve recognition, assessment, and treatment of mental illness and depression among older Americans (WHCOA, 2005).
- SAMHSA's Transforming Mental Health Care in America initiative included older adults among its target groups for a seamless system designed to help people achieve their maximum potential in all spheres of life and at all points in their development (SAMHSA, 2005). The initiative called for SAMHSA, CDC, and the Health Resources and Services Administration to collaborate in helping to serve older adults.

As a result of this attention to the mental health problems of older adults, the once-separate public health and mental health systems are starting to work more closely together to address depression among older adults. In the past, public health focused on surveillance for health behaviors and chronic disease in order to plan public health programs, while the mental health field used a separate data collection system that emphasized measurement of disease prevalence and health care use (Freeman, 2010). Recent efforts to integrate these systems have included adding chronic disease measures to the Collaborative Psychiatric Epidemiology Surveys and incorporating depression measures in the BRFSS and other data collection systems (Freeman, 2010).

WHAT IS DEPRESSION?

"Everyone feels sad or blue sometimes. It is a natural part of life. But when the sadness persists and interferes with everyday life, it may be depression. Depression is not a normal part of growing older. It is a treatable medical illness, much like heart disease or diabetes."

– Geriatric Mental Health Foundation

The Surgeon General in 1999 identified mental health as a state of "successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity." Mental disorders, on the other hand, are characterized by "alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning."

Research indicates depressive illnesses are disorders of the brain (NIMH, 2007). Depression has no known cause, but is believed to result from several genetic, biochemical, environmental, or psychological factors. Depression is treatable in 80 percent of cases (NIMH, 2007).

However, depression may be overlooked in older adults, because they may show different or less obvious symptoms than younger people, and may be less inclined to experience or acknowledge feelings of sadness or grief (Gallo, 1999). Depression in older adults must also

be distinguished from the effects of medical conditions or prescription medications that may cause depressive symptoms.

Older adults are less likely than younger adults to have major depression, but have higher rates of minor depression and dysthymia (Ciechanowski, 2004) – both conditions contribute to significant disability (Wells, 1989; Beekman, 1997).

Types of Depression

Major depression is defined as depressed mood most of the day or loss of interest or pleasure over a two-week period accompanied by at least four of the following symptoms: significant weight loss or gain, insomnia or sleeping too much nearly every day, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, inability to think or concentrate, or recurrent thoughts of death. In elderly adults, cognitive symptoms (e.g., disorientation, memory loss, and distractibility) may be particularly prominent.

Minor depression is one or more periods of depressive symptoms that have lasted for two weeks or longer, but with fewer symptoms and less impairment than major depression. An episode involves either a sad or depressed mood or loss of interest or pleasure in nearly all activities.

Dysthymic disorder, or dysthymia, is a long-term (two years or longer) depressed mood for most of the day, for more days than not, accompanied by two or more of the following: poor appetite or overeating, insomnia or sleeping too much, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. The symptoms are less severe than depression.

Source: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. , Text Revision, 2000.

HOW MANY OLDER ADULTS HAVE DEPRESSION?

Estimates of the prevalence of depression among older adults range from 15–20 percent of adults older than 65 (Ciechanowski, 2004; GMHF, 2008; Koenig, 1996; Lebowitz, 1996). The levels are lower among community-dwelling older adults and higher among those in nursing homes (Lebowitz, 1996).

Another study, which looked at clients aged 60 years and older receiving in-home case management services through 13 area agencies on aging in Washington State, found an estimated 20–30 percent of older adults have minor depression, and 25 percent have major depression, according to Dr. Mark Snowden, M.D., M.P.H., Department of Psychiatry and Behavioral Sciences, University of Washington School of Medicine.

On the BRFSS, 7.7 percent of adults age 50 or older reported current depression, and 15.7 percent reported a lifetime diagnosis of depression. However, certain groups reported different levels of depression at age 50 or older (CDC, 2008):

- Hispanic, 11.4 percent
- Other non-Hispanic, 11.0 percent
- Black, non-Hispanic, 9.0 percent
- White, non-Hispanic, 6.8 percent

Women aged 50 years and older also reported more current depression (8.9 percent of women are currently depressed, compared with 6.2 percent of men) and lifetime depression (19.1 percent of women compared with 11.7 percent of men) (CDC, 2008).

Interestingly, adults aged 50–64 years reported more current depression (9.4 percent of those aged 50–64, compared with 5 percent of those aged 65 or older) and lifetime diagnosis of depression (19.3 percent of those aged 50–64, compared with 10.5 percent of those 65+) (CDC, 2008). Some experts suggest this may be due to the stress of the preretirement years.

COST OF UNTREATED DEPRESSION

Depressed older adults have higher health care expenses because they are more likely to visit the Emergency Department, have more frequent hospitalizations and doctor visits, and take more medications than adults without depression, according to the U.S. Surgeon General's report (1999).

For example, Medicare participants who have diabetes or congestive heart failure as well as depression have significantly higher health care costs than their counterparts who do not have co-existing depression, according to a study funded by the National Institute of Mental Health. Jürgen Unützer, M.D., M.P.H., of the University of Washington, and colleagues analyzed Medicare claims of 14,903 participants enrolled in a pilot Medicare disease management program, Medicare Health Support, operated by Green Ribbon Health in Florida (Unützer, 2009). The researchers found those with depression and chronic disease had significantly higher total health care costs than those with chronic disease but no depression (\$22,960 vs. \$11,956) (Unützer, 2009). Only a small proportion of the increased costs are from mental health specialty care.

There are other costs of untreated depression besides monetary costs, including poor quality of life and possible suicide. People aged 65 years and older accounted for 16 percent of suicides in 2004 (CDC, 2007).

SCREENING GUIDELINES

Screening for depression allows professionals to look for the condition in patients who do not report symptoms, according to the U.S. Preventive Services Task Force (USPSTF). Screening should only be offered when there are services or systems in place to immediately refer the patient for further assessment, treatment, and follow-up (USPSTF, 2002). Screening by itself, without treatment and follow-up, is not effective, USPSTF concluded after a research review completed in 2009 (USPSTF, 2009; O’Conner, 2009). Operated by the U.S. Agency for Healthcare Research and Quality, USPSTF is a group of health experts who review published research and make recommendations about preventive health care.

Screening should be done in an appropriate setting, using a depression screening instrument appropriate for an older adult population, Dr. Snowden said. Examples of depression screening tools include the Geriatric Depression Scale, the Center for Epidemiologic Studies Depression Scale, and the Patient Health Questionnaire. While screening identifies the likelihood someone may have depression, it is not in itself a diagnosis, Dr. Snowden added. Diagnosis and treatment should be offered by someone trained in evaluating depression symptoms and other medical problems associated with depression (Snowden, 2009).

TREATING DEPRESSION

“CDC research revealed several important studies that identified depression care programs that work, that communities can engage in, that we know are going to have the desired outcomes and effect on depression” –Lynda Anderson, Ph.D., director of CDC’s Healthy Aging Program

For older adults (age 60+), the top recommended treatment is home- or clinic-based depression care management (DCM), according to the nonfederal Task Force on Community Preventive Services, whose members are appointed by CDC. The recommendations are contained in the *Guide to Community Preventive Services* (commonly known as the *Community Guide*) (TFCPS, 2007). The panel also endorsed cognitive behavior therapy for treating late-life depression, although not as strongly as DCM. The ratings are based on the evidence of effectiveness in improving short-term depression outcomes.

The task force concluded that these recommended programs – DCM and cognitive behavior therapy (CBT) – “should be disseminated throughout public health and aging networks while acknowledging the challenges and obstacles involved” (Snowden, 2007).

DCM, sometimes called collaborative care management, uses a team approach. A trained social worker, nurse, or other practitioner (sometimes called a depression care manager)

oversees patient education, outcomes tracking, and support/delivery of the evidence-based treatments that a primary care provider prescribes in consultation with a psychiatrist (Snowden, 2007). DCM was supported by eight randomized clinical trials with more than 3,000 subjects, who reported a greater reduction in depression symptoms, higher remission rates, and more improvements in health-related quality of life than people in the control group (Snowden, 2008).

Home-based DCM is designed for older adults living in their own homes, public housing, or residential facilities. It involves home visits by a trained depression care manager, who work with other team members (case manager and supervising psychiatrist) outside the home. In studies examined by the Task Force, the response rate to home-based DCM ranged from 27–43 percent for the intervention group compared with 15 percent for the control group. “Response” was defined as a 50 percent reduction in depression measure scores. The remission rate, which refers to absence of symptoms of depression, was 36 percent for the intervention group versus 12 percent for the control group (TFCPS, 2007). The total mean cost for the one program that reported costs was \$630 per patient for six visits.

In clinic-based DCM, a trained depression care manager works with the patient’s primary care provider, psychiatrist, or other health care personnel, employing patient education, antidepressant treatment and/or psychotherapy, and supervision by a psychiatrist. One research study of clinic-based DCM reported a 45 percent response rate and a 25 percent remission rate for subjects with major depression or dysthymia (TFCPS, 2007). Another study found a 55 percent response rate and a 36 percent remission for subjects with major depression after a similar time period; no statistically significant improvement was found for subjects with minor depression (Bruce, 2002). Costs for the depression care had a mean cost of \$580 per patient (Unützer, 2002).

CBT is psychotherapy focusing on clients’ patterns of thought and behaviors that induce a depressed mood (Snowden, 2008). The therapist educates the client on how to identify and change these thoughts and behaviors to relieve the depression symptoms. Generally the therapist has a master’s degree and is supervised by someone with an M.D. or Ph.D. (Steinman, 2007). CBT was determined to be an effective intervention, regardless of whether delivered in the home or clinic, according to Dr. Snowden.

Dr. Snowden, with support from the CDC Healthy Aging Program and Community Guide Staff, made several presentations to the Task Force on Community Preventive Services that resulted in the task force's independent recommendations about depression interventions for older adults. "As a result, the task force came out with *Community Guide* recommendations for the first time on preventive services for older adults about mental health," Dr. Anderson said.

However, "Just because the *Community Guide* recommends something, doesn't guarantee things are likely to change," Dr. Snowden explained. "It is not enough to just fund studies that prove an intervention is effective if those interventions never get out into everyday use." So CDC funded a dissemination and implementation study to find out what needed to be done to put the interventions into practice. The study by the University of Washington found that once research was completed, the community-based agency was often able to continue the project on its own; however, case managers were not referring patients to the program. The researchers decided to re-establish the research-phase partnership with the community-based agency that participated in the study in order to figure out ways for the agency to continue to use the program. One DCM program was modified to lower the eligibility age from 60 to 50, allow the intervention to be used for major depression as well as minor depression, hire a recruiter/coordinator to help facilitate the evidence-based programs and take the burden off the case manager, allow a language interpreter to go into a patient's home, and improve monitoring so the agency could assess progress. Those changes help ensure more patients can access the program, according to Dr. Snowden.

In addition, Washington State and others are experimenting with ways to provide sustainable funding for DCM programs. For example, a King County, Washington, tax levy for homeless veterans was expanded to include older adults. This provided funds for a DCM known as the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) to begin to reach older veterans and underserved minorities. A SAMHSA grant was used for intervention training and to create a PEARLS toolkit for community-based providers.

MODEL PROGRAMS FOR TREATING DEPRESSION IN OLDER ADULTS

Below are descriptions of three model DCMs used with older adults.

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), developed by Baylor College of Medicine and others, focuses on underserved, frail, community-dwelling adults age 60 and older who are receiving case management services. The program provides depression care in the participant's home. Participants and their caregivers receive education about depression and self-care and assistance in contacting primary care and mental health

providers. The program provides coaching and support as the client engages in behavioral changes to manage depression and pursue meaningful activities. It generally involves three in-person visits and three to six telephone calls over three to six months (CDC, 2009).

The interventionist does not have to have professional licensure and receives on-site training. Other resources include a manual, worksheets, client handouts, and forms to document client outcomes.

Researchers found that participants in the program lowered their levels of depression and pain, learned where to get help for depression, and engaged in more activities.

The program cost is \$3,000 for training and set-up. Per-patient costs have not been determined.

Care for Elders in Houston and Baylor College of Medicine manage the dissemination of Healthy IDEAS to potential adopters. Contact: Nancy Wilson, nwilson@bcm.edu, 713-798-3850; <http://careforelders.org/default.aspx/MenuItemID/290/MenuGroup/Initiatives.htm>.

The U.S. Administration on Aging has awarded a grant to Sheltering Arms Senior Services in Houston, Texas, to build on the Healthy IDEAS program, with a focus on underserved and minority older adults. The goal is to improve partnerships between community aging service providers, health care organizations, academic researchers, and consumers.

IMPACT (Improving Mood – Promoting Access to Collaborative Treatment) is a clinic-based depression care management program developed at the University of Washington for older adults with major depression or dysthymic disorder. It employs a trained nurse, social worker, or psychologist, who teaches clients problem-solving techniques, in coordination with a primary care physician who may prescribe antidepressant medications. A psychiatrist provides consultation and supervision as needed. IMPACT was designed for a clinical setting, but has also been implemented in home health care and chronic disease management programs.

Participants receive an assessment and education about depression, and are urged to engage in physical activity or schedule pleasurable events. Clients who are taking antidepressant medications and continue to be depressed are offered a six- to eight-session trial of problem-solving treatment. The DCM follows up about every two weeks during the intensive phase and then monthly thereafter for several months (CDC, 2009).

IMPACT participants were twice as likely as usual-care patients to have a 50 percent or higher reduction in their symptoms (CDC, 2009). The program also reduces total health care costs by about \$3,300 per person over a four-year period, compared with usual care (Unützer, 2008).

The yearly cost of the program is about \$750 per participant. Free program materials are available online; however, there is an in-person training cost of about \$250.

Contact: Diane Powers, powersd@u.washington.edu, 206-685-7095; <http://impact-uw.org/>.

PEARLS (Program to Encourage Active, Rewarding Lives for Seniors) is a home-based depression care management program for minor depression and dysthymia in adults aged 60 years and older who are receiving home-based social services from community services agencies. PEARLS offers eight in-home counseling sessions and three to six maintenance followup telephone calls. A trained depression care manager, usually a social worker or mental health counselor, uses problem-solving treatment, social and physical activity planning, and pleasant-event planning (CDC, 2009). The depression care manager works closely with a supervising psychiatrist.

PEARLS significantly reduced depressive symptoms and improved health status in chronically medically ill older adults (Ciechanowski, 2006). Participants were three times more likely than those receiving usual care to significantly reduce their symptoms of depression (43 percent vs. 15 percent) or completely eliminate depression (36 percent vs. 12 percent) (CDC, 2009). Participants were also more likely to report greater health-related quality of life improvements (functional as well as emotional well-being) and reduce their use of health care services, such as hospitalization. The University of Washington developed PEARLS in the late 1990s.

The cost of the program is about \$630 per patient. Resources include a DCM manual, implementation toolkit, and \$500 training program in Seattle twice a year.

Contact: Lesley Steinman, 206-543-9837, lesles@uw.edu, www.pearlsprogram.org.

BARRIERS TO CARE

Because effective programs for treating depression in older adults exist and are recommended, why don't more older adults access them? There are various barriers that keep effective treatment programs, known as evidence-based programs or EBPs, from being used.

One barrier is that many older adults and society itself tends to have a stigma against mental illness, viewing depression as a personal weakness or character flaw (Kobau, 2010). Many older adults are reluctant to go to a mental health specialist (Snowden, 2008). "Some older persons believe that mental health disorders and treatment are shameful, represent personal failure, or will lead to a loss of autonomy. As a result, they may deny having problems or refuse to seek treatment," attendees at the 2005 White House Conference on Aging concluded.

CDC collects data on mental health stigma through two questions on the BRFSS. It asks the respondent if he or she agrees: 1) "treatment can help people with mental illness lead normal lives" and 2) "people are generally caring and sympathetic to people with mental illness."

In addition to stigma, ageism and erroneous assumptions that depression is a normal part of aging may cause practitioners to miss a potential depression diagnosis. A significant step toward addressing stigma would be for the public and practitioners to better understand that depression is common and treatable (Steinman, 2007). Another problem is many primary care clinics do not usually screen for depression (Snowden, 2008).

Another obstacle to accessing treatment is many EBPs for depression have not been tested among all population cohorts, especially non-English-speaking populations, lower-income people, people of color, people older than age 85 and those with cognitive impairments (Steinman, 2007).

A significant hurdle to accessing care is that Medicare and other insurers do not cover depression care unless it is provided by physicians, psychologists, licensed clinical social

workers, or advanced RN practitioners (Steinman, 2007). In some cases Medicare and Medicaid will not reimburse for a registered nurse serving as a case manager or for a supervising psychiatrist (Snowden, 2008). Yet many of the EBPs developed for addressing depression in older adults can be administered by a well-trained person with a bachelor's degree.

Without payment, however, it is difficult to provide properly trained and supervised staff to deliver the EBP.

Another common problem with EBPs is that once the initial research is completed, they often "sit on the shelf" without being disseminated and used. One solution is the University of Washington's previously described approach to revise the original program to better match a community's unique needs.

In addition, public health and agencies on aging do not traditionally work together in the area of mental health.

FUTURE DIRECTIONS

"Because the condition is highly treatable and currently undertreated among community-based older adults, late-life depression is an appropriate focus for disease prevention programs."

– Mark Snowden (Snowden, 2008)

Policymakers clearly need to understand that EBP for depression can improve treatment outcomes and lower health care costs (Steinman, 2007). Treating depression effectively also can help improve arthritis, diabetes, cancer, and other disease outcomes (Steinman, 2007).

The public health, mental health, and aging services networks need to work together more closely to reach and treat older adults with depression. Public health and agencies on aging can do this by creating partnerships and collaborative care programs to identify, reach, and treat older adults with depression. Such a collaborative approach would allow consistent information to be disseminated to each of these sectors, instead of the current model under which CDC reaches out to state and local public health departments, SAMHSA communicates with state mental health programs and mental health providers with treatment information, and the Administration on Aging reaches the network on aging with service information. Better packaging of information about depression in older adults could produce a useful toolkit for professionals who work with them.

"The public health community needs to understand the seriousness of depression among older adults, understand the need to work with the mental health communities in state health departments and in local areas, and understand that there are effective services out there

for older adults,” Dr. Anderson said. “Whereas the aging services network, which is more services oriented, can begin by looking at how to implement those kinds of programs and work with the public health community to help organize and connect to these programs.”

Public health professionals can help the aging services network with the collection and analysis of data on depression among older adults and with tracking, evaluation, and identification of programs that are effective, Dr. Anderson said.

In addition, public health disease prevention programs for older adults should include a depression screening and treatment component, according to Dr. Snowden (Snowden, 2008).

On the financing side, Medicare and other insurers could cover evidence-based programs for depression, giving more older adults access to depression treatment.

At the same time, more research is needed to understand how well depression care programs will work with nontraditional populations outside the academic setting, in places such as senior centers and area agencies on aging. Another area requiring more research is the effect of physical activity on depression.

Efforts also need to focus on pre-Medicare-age adults. In *Promoting Preventive Services for Adults 50–64: Community and Clinical Partnerships* (CDC, 2009c), CDC, AARP and American Medical Association, lay out a plan to promote clinical preventive services for adults aged 50 to 64 years. “Widespread agreement exists on a recommended array of preventive services and effective ways to increase their use,” the document states. The report recommends using preventive services for this age group, including depression screening and management.

States can also use existing data to identify older adults enrolled in case management who have a depression score showing they are at risk and might benefit from services like PEARLS. That data can also help the aging services network look at how local communities can finance and deliver services.

In the future, public health surveillance systems will focus more on psychological well-being by measuring positive psychological function as both a protective factor against poor health outcomes and as a mental health indicator in its own right (Freeman, 2010). Well-being looks at the degree to which people feel positive and enthusiastic about themselves and life (Manderscheid, 2010).

This document is available online at www.cdc.gov/aging. It was written by Nancy Aldrich. William F. Benson was senior editor and project manager.

STORY IDEAS FOR JOURNALISTS

- 1) Help your readers overcome the stigma about mental health and depression issues. Address people's reluctance to admit having depression. Interview older adults who were reluctant to seek treatment due to stigma, but got over the stigma, received treatment, and report that their life is better and they can now solve their problems.
- 2) Write a story about the need for public health departments to focus more on mental health issues among older adults.
- 3) When writing about a new intervention or treatment for depression in older adults, ask how many people are receiving this intervention. Is it something that will "sit on the shelf," or is there a mechanism in place to ensure its widespread use?
- 4) Investigate why Medicare and other insurers will only pay for mental health services provided by certain levels of professionals, when many evidence-based programs can effectively be provided by a properly trained professional with a bachelor's degree.

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ADDITIONAL RESOURCES:

- Age Page: Depression, <http://www.nia.nih.gov/healthinformation/publications/depression.htm>
- American Association for Geriatric Psychiatry, www.aagppga.org.
- Centers for Disease Control and Prevention, www.cdc.gov/mentalhealth.
- Center for Mental Health Services, U.S. Substance Abuse and Mental Health Services Administration, <http://mentalhealth.samhsa.gov>.
- Depression in late life: not a natural part of aging, www.gmhfonline.org/gmhf/consumer/factsheets/depression_latelife.html.
- Geriatrics and mental health: the facts, www.aagponline.org/prof/facts_mh.asp.
- Health care costs much higher for older adults with depression plus other medical conditions, www.nimh.nih.gov/science-news/2009/health-care-costs-much-higher-for-older-adults-with-depression-plus-other-medical-conditions.shtml.
- How do older adults experience depression?, www.nimh.nih.gov/health/publications/depression/how-do-older-adults-experience-depression.shtml.
- Mental health: a report of the surgeon general, www.surgeongeneral.gov/library/mentalhealth/home.html
- Mental Health America, www.nmha.org.
- National Alliance on Mental Illness, www.nami.org.
- National Institute of Mental Health, www.nimh.nih.gov.
- National Institutes of Health SeniorHealth: Depression, <http://nihseniorhealth.gov/depression/toc.html>.
- National Suicide Prevention Lifeline, 1-800-273-8255
- Older adults: depression and suicide facts, www.nimh.nih.gov/publicat/elderlydepsuicide.cfm.
- Positive Aging Resource Center, www.positiveaging.org/.
- State of mental health and aging in America, <http://apps.nccd.cdc.gov/MAHA/MahaHome.aspx>.
- WHO Initiative on Depression and Public Health, www.who.int/mental_health/management/depression/depressioninph/en/.

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